

<b>APPLICATION FOR FEDERAL ASSISTANCE</b>		2. DATE SUBMITTED 7/14/2005	APPLICANT IDENTIFIER
1. TYPE OF SUBMISSION:		3. DATE RECEIVED BY STATE	STATE APPLICATION IDENTIFIER
Application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	Pre-application <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction	4. DATE RECEIVED BY FEDERAL AGENCY	FEDERAL IDENTIFIER
<b>5. APPLICANT INFORMATION</b>			
Legal Name: State of California		Organizational Unit: Title V Agency: MCAH Branch/CMS Branch	
Address (give city, county, state and zip code) 1615 Capitol Avenue, 5th Floor PO Box 997420 MS 8300 Sacramento, CA 95899 County: Sacramento		Name and telephone number of the person to be contacted on matters involving this application (give area code) Name: Susann J. Steinberg, MD; Marian Dalsey, MD, MPH Tel Number: 916-650-0300	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): <div style="border: 1px solid black; padding: 2px; display: inline-block;">680317191</div>		7. TYPE OF APPLICANT: (Enter appropriate letter in box) A A. State                      H. Independent School District B. County                  I. State Controlled Institution of Higher Learning C. Municipality           J. Private University D. Township              K. Indian Tribe E. Interstate              L. Individual F. Intermunicipality     M. Profit Organization G. Special District      N. Other (Specify)	
8. TYPE OF APPLICATION: <input type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) <input type="checkbox"/> <input type="checkbox"/> A. Increase Award B. Decrease Award C. Increase Duration Decrease Duration Other (specify):		9 NAME OF FEDERAL AGENCY: Health Resources and Services Administration, Maternal and Child Health Bureau	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: <div style="border: 1px solid black; padding: 2px; display: inline-block;">93994</div> TITLE: Maternal and Child Health Services Block Grant		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Title V Block Grant Application & Progress Report	
12. AREAS AFFECTED BY PROJECT (cities, communities, states, etc.): State of California			
13. PROPOSED PROJECT:		14. CONGRESSIONAL DISTRICTS OF:	
Start Date: 10/01/2005	Ending Date: 09/30/2006	a. Applicant All California Districts	b. Project All California Districts
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$ 47,947,194.00	a. YES, THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:	
b. Applicant	\$ 0.00	b. NO <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372	
c. State	\$ 855,004,850.00	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$ 0.00		
e. Other	\$ 0.00		
f. Program Income	\$ 787,434,311.00		
g. TOTAL	\$ 1,690,386,355.00	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT <input type="checkbox"/> Yes. If "Yes", attach an explanation <input checked="" type="checkbox"/> No	
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY BY THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.			
a. Typed Name of Authorized Representative Susann J. Steinberg, MD; Marian Dalsey, MD, MPH		b. Title Chief, MCAH Branch; Acting Chief, CMS Branch	
c. Telephone Number 916-650-0300		d. Signature of Authorized Representative <i>Susann J. Steinberg, MD</i>	
e. Date Signed 7/12/05			

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Standard Form 424 (REV. 4-88)  
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